



U.S. Department of State
VACCINATION DOCUMENTATION WORKSHEET
For Use with DS-2053 To Be Completed by Panel Physician Only

OMB No. 1406-0113
EXPIRATION DATE: 1/31/2004
ESTIMATED DURATION: 30 minutes
(See Page 2 - Back of Form)

Name (Last, First, MI)					Exam Date (mm-dd-yyyy)		REQUIRED FOR U.S. EMIGRANT VISA APPLICANTS				
Birth Date (mm-dd-yyyy)		Passport Number		Alien (Case) Number		NOT REQUIRED FOR REFUGEE APPLICANTS					
1. Immunization Record							NOTE FOR PANEL PHYSICIANS: For refugee applicants, please complete only if reliable vaccination documents are available.				
Vaccine History Transferred From a Written Record (list chronologically from left to right)					Vaccine Given by Panel Physician (mm/dd/yyyy)	Completed Series (✓ if completed, write "VH" if varicella history, or write date of lab test if immune)	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below				
Vaccine	Date received (mm/dd/yyyy)	Date received (mm/dd/yyyy)	Date received (mm/dd/yyyy)	Date received (mm/dd/yyyy)			Not age appropriate	Insufficient time interval	Contra- indicated	Not routinely available	Not fall (flu) season
DT/DTp/DTaP											
Td											
Polio (OPV/IPV)											
Measles											
Mumps (or MMR)											
Rubella (or MR or MMR)											
Hib (Haemophilus influenzae type b)											
Hepatitis B											
Varicella											
Pneumococcal											
Influenza											
2. Results											
<input type="checkbox"/> Vaccine history incomplete											
<input type="checkbox"/> Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate (as indicated above).											
<input type="checkbox"/> Applicant will request an individual waiver based on religious or moral convictions.											
<input type="checkbox"/> Vaccine history complete for each vaccine, all requirements met (documented above).											
<input type="checkbox"/> Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.											
						3. Panel Physician (name) _____					
						Panel Physician (signature) _____					
						Date (mm/dd/yyyy) _____					



PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: Department of State (A/RPS/DIR) Washington, DC 20520-1849.

We ask for the information on this form in the case of applicants for immigrant visas to determine medical eligibility under INA Sections 212(a) and 221(d) and as required by INA Section 212(g)(2). If an immigrant visa is issued, you will convey this form to the INS for disclosure to the Center for Disease Control and the Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If your Immigrant visa is not issued, this form will be treated as confidential under INA Section 222(f).